Clear Form Entries

Head and Spinal Cord Injury Division

Assessment for Individual Rehabilitation Supports and HASCI Community Opportunities Model

Date Completed _____

Name: _____ SSN: _____ Medicaid#: _____

Street Address: _____ Apt.#: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____) _____ DOB: _____ Age: _____ Sex: ☐ Male ☐ Female

Name of Emergency Contact Person: _____ Phone: (_____) _____

DIAGNOSIS / BACKGROUND INFORMATION: (check all that apply)

☐ Traumatic Brain Injury ☐ Spinal Cord Injury: Level of Injury _____ ☐ Similar Disability *(specify)* _____

Month/year of injury: _____ Age when injured: _____ If Similar Disability, Age of onset: _____

Type of injury and how it occurred: _____

Do you receive Home and Community-based Medicaid Waiver services? ☐ Yes ☐ No

If YES, which Waiver? ☐ Elderly Disabled(ED) ☐ Ventilator Dependent for Adults(VENT) ☐ HIV/AIDS ☐ MR/RD ☐ HASCI

If YES, please list the agency providing the Waiver services: _____

Do you receive services from any other agencies? ☐ Yes ☐ No If YES, please list agency(s): _____

_____

Were you employed or in school at the time of your injury? ☐ Yes ☐ No

Were you employed after your injury? ☐ Yes ☐ No Are you currently employed? ☐ Yes ☐ No

What is the highest level of education you completed? _____

Comments: _____

MEDICAL HISTORY:

Do you have a primary physician? ☐ Yes ☐ No

If yes, primary physician name: _____ Phone Number: (_____) _____

Do you have regular check-ups with your physician? ☐ Yes ☐ No

Additional medical conditions: _____

Allergies: _____

Do you have a dentist? ☐ Yes ☐ No Do you keep yearly appointments with your dentist? ☐ Yes ☐ No

Do you have any type of health care coverage that pays for all or part of your medical care? ☐ Yes ☐ No

If YES, please list: _____

SPECIFIC AREAS OF DIFFICULTY: (check all that apply) Body Pain

☐ Headaches	☐ Nutrition	☐ Frustration
☐ Seizures	☐ Self-care	☐ Impulsiveness
☐ Vision	☐ Short term memory	☐ Anger
☐ Hearing	☐ Long term memory	☐ Depression
☐ Speech	☐ Cognitive reasoning	☐ Isolation
☐ Health	☐ Organizational skills	☐ Say inappropriate things
☐ Paralysis	☐ Medication Management	☐ Social skills
☐ Mobility	☐ Money Management	☐ Relationships with others
☐ Coordination	☐ Judgement	☐ Accessing community resources
☐ Fine motor skills dexterity	☐ Confusion	☐ Vocational Opportunities
☐ Spasticity	☐ Attention	☐ Sexuality
☐ Balance	☐ Mood	☐ Behavior problems
☐ Endurance	☐ Motivation	☐ Alcohol/substance abuse

☐ Other _____

Please explain any of these, if necessary: _____

_____

_____

_____

Specific Areas of Difficulty – continued…

What devices, aids, and other equipment do you currently use?

- ☐ Manual wheelchair
- ☐ Power wheelchair
- ☐ Shower chair
- ☐ Writing splint or other aid
- ☐ Walker
- ☐ Regular or quad cane
- ☐ Lap tray
- ☐ Prescriptive cushion
- ☐ Reachers / grabbers
- ☐ Adapted eating / drinking utensils
- ☐ Adapted shaving devices
- ☐ Adapted toothbrush devices
- ☐ Adapted grooming aids, brushes, combs
- ☐ Toileting aids
- ☐ Environmental control system
- ☐ Personal Emergency Response Systems (PERS)
- ☐ Cordless phone, speaker phone, or other access device
- ☐ Transfer board or aid
- ☐ Lift-equipped van
- ☐ Hoyer lift or overhead track lift

Comments: _____

Assessment of the following must be performed:

1. SELF CARE (cognitive/independent living skills)

Please check your current living arrangements:

- ☐ Independent living (manages own household)
- ☐ With spouse
- ☐ With parents
- ☐ With significant other
- ☐ Residential care facility
- ☐ Nursing home
- ☐ Other, *(specify)*: _____

Who is your primary staff? _____ What is his/her age? _____

Are you satisfied with your current living arrangements? ☐ Yes ☐ No

Tell me about the things you are good at. (List personal strengths, positive qualities/skills) _____

_____

_____

Does your disability limit your ability to feed yourself and prepare meals or snacks? ☐ Yes ☐ No

If YES, who primarily assists you? _____

Do you receive the assistance of others in bathing/showering, dressing, grooming, or toileting? Please check one of the following:

- ☐ Independent
- ☐ Require limited assistance
- ☐ Require considerable assistance

Comments: _____

Planning Skills

Describe how you would plan a typical day at home from the time you wake up in the morning until you go to sleep at night:

_____

_____

_____

Give an example of an activity you planned or coordinated for yourself and/or friends in the last two weeks. _____

_____

_____

Would you like to learn more about techniques to help organize your life/day? ☐ Yes ☐ No

If YES, please describe: _____

_____

Do you have a computer with internet access? ☐ Yes ☐ No

Do you need training on how to use your computer? ☐ Yes ☐ No ☐ N/A

Comments: _____

Self Care (cognitive/independent living skills) – continued…

Memory

Please check N/A if this section does not apply to you: ☐ N/A

How often do you have difficulty remembering important things that you must do?

☐ I almost always have difficulty.

☐ I sometimes have difficulty.

☐ I almost never have difficulty.

What tools do you use to help you remember what you need to get done? _____

_____

Comments: _____

Concentration

I react slowly to things that are said or done. ☐ Yes ☐ No ☐ Sometimes

I am confused and start several actions at a time. ☐ Yes ☐ No ☐ Sometimes

I forget a lot, for example, things that happened recently, where I put things, appointments. ☐ Yes ☐ No ☐ Sometimes

I don't keep my attention on any activity for long. ☐ Yes ☐ No ☐ Sometimes

I have difficulty doing activities involving concentration and thinking. ☐ Yes ☐ No ☐ Sometimes

Comments: _____

2. MEDICATION MANAGEMENT AND SYMPTON REDUCTION

Please complete the following regarding current medications:

Medication	Reason Prescribed	Medication Dosage/Schedule	Physican/Prescriber

Do you take your medication on schedule and without reminders? ☐ Yes ☐ No ☐ N/A

Does anyone assist you in taking your medications? ☐ Yes ☐ No ☐ N/A

If YES, explain: _____

Do you use compensatory aids to remind you to take your medication(s)? ☐ Yes ☐ No ☐ N/A

If YES, explain: _____

Comments: _____

3. HEALTH AND NUTRITION

In general would you say your health is:

- ☐ excellent
- ☐ very good
- ☐ good
- ☐ fair
- ☐ poor

Please list your weight _____ and height _____

In the last month have you accomplished less than you would like as a result of your physical health? ☐ Yes ☐ No

If YES, explain: _____

How many times a week do you exercise?

- ☐ none
- ☐ 1 to 2
- ☐ 3 to 4
- ☐ more than 4

When you exercise, for how long do you exercise?

- ☐ less than 10 minutes
- ☐ 10-20 minutes
- ☐ 20-30 minutes
- ☐ more than 30 minutes

When you exercise, do you exercise with anyone else? ☐ Yes ☐ No

Would you like to make any changes to your current activity level? ☐ Yes ☐ No If YES, what? _____

_____

What types of exercise do you enjoy? _____

Have you discussed your exercise goals with your doctor? ☐ Yes ☐ No

How do you relieve tension and stress? _____

Would you like to learn more about exercise and relaxation techniques? ☐ Yes ☐ No

Would you like any additional information to help you with your exercise goals? ☐ Yes ☐ No

Do you shop for your groceries? ☐ Yes ☐ No

How many meals do you eat each day?

- ☐ One
- ☐ Two
- ☐ Three
- ☐ More than three

Do you eat at least three servings of vegetables each day? ☐ Yes ☐ No If NO, explain: _____

Do you eat at least two servings of fruit each day? ☐ Yes ☐ No If NO, explain: _____

Do you take a multivitamin on a regular basis? ☐ Yes ☐ No

Do you eat foods that are high in fiber? ☐ Yes ☐ No ☐ Sometimes

If YES, what types and how often? _____

If NO, explain: _____

How many glasses of water do you drink each day? _____ If less than eight (8), explain: _____

Do you have any food allergies? ☐ Yes ☐ No If YES, what type? _____

_____

Would you like help with learning how to prepare healthy meals? ☐ Yes ☐ No

Would you like to learn more about proper nutrition? ☐ Yes ☐ No

Health and Nutrition – continued…

During the past month, how many days per week or month did you drink any alcoholic beverages? _____

On the days when you drank alcoholic beverages, about how many drinks did you drink on average? _____

Have you ever received mental health services? ☐Yes ☐No If YES, explain: _____

_____

Are you currently receiving mental health services? ☐Yes ☐No If YES, please list provider(s): _____

_____

Would you like to receive mental health services? ☐Yes ☐No

Have you ever been arrested? ☐Yes ☐No If YES, what was the reason? _____

_____

If YES, was it ☐Before injury ☐After injury ☐Both

Secondary Conditions

The following three questions should ONLY be answered if you have a spinal cord injury above the T6 level.

Has a medical professional ever explained what autonomic dysreflexia is and are you familiar with what can cause it? _____

_____

What is your emergency plan in the event you experience autonomic dysreflexia? _____

_____

Do you carry a card in your wallet explaining autonomic dysreflexia? ☐Yes ☐No

Comments: _____

Secondary Conditions - continued

Please check N/A if the following does not apply to you. ☐ **N/A**

Do you accomplish your bowel program independently or do you require the assistance of others?
☐Independent ☐Require Limited Assistance ☐Require Assistance

Do you accomplish bladder management by self-catheter? ☐Yes ☐No
If YES, what type?: ☐Condom type catheter ☐Ostomy ☐Other

Are you able to independently perform self-catheterization? ☐Yes ☐No

Have you ever had a urinary tract infection (UTI)? ☐Yes ☐No If YES, how frequently? _____

What precautions do you take to prevent getting a UTI? _____

How often do you perform pressure reliefs? _____

Have you ever had a decubitus ulcer or skin breakdown? ☐Yes ☐No

Do you, or do you have your attendant, check your skin regularly for reddened areas? ☐Self ☐Attendant ☐Both

Do you require attendant care for some of your daily activities? ☐Yes ☐No If YES, how often? _____

Do you fund your own attendant care program or do you use attendants through a Waiver program? ☐Self ☐Waiver Program

Do you train your attendant(s) for your specific care needs? ☐Yes ☐No

Do you have a plan in case your attendant does not show up for work? ☐Yes ☐No
If YES, who do you contact? _____

Comments: _____

4. SELF ESTEEM

Do you think you have problems with self-esteem?	☐ Yes	☐ No	Are you happy with your life?	☐ Yes	☐ No
			Do you have a positive attitude?	☐ Yes	☐ No
Do you feel you have good qualities?	☐ Yes	☐ No	Do you feel proud of yourself?	☐ Yes	☐ No
Are you happy with yourself?	☐ Yes	☐ No	Do you respect yourself?	☐ Yes	☐ No

Comments: _____

5. COPING SKILLS

What do you do when you are frustrated? _____

How do you solve problems? _____

Can you give an example of a recent problem you had and how you handled the problem? _____

Would you like to learn more about how to resolve your problems? ☐ Yes ☐ No

Comments: _____

6. PERSONAL RESPONSIBILITY AND SELF-DIRECTION

Do you use a calendar or monthly planner to maintain your personal schedule? ☐ Yes ☐ No

Do you schedule your own appointments? ☐ Yes ☐ No If NO, who does? _____

Do you use any assistive technology devices to help you with your personal schedule? ☐ Yes ☐ No

If YES, please list the devices: _____

If NO, do you need assistive technology devices and training to help you? ☐ Yes ☐ No

If you could have help changing two (2) things in your life, what would you change? _____

Comments: _____

7. SOCIAL SKILLS AND POSITIVE INTERACTIONS WITH OTHERS

Do you have difficulty communicating with others? ☐ Always ☐ Sometimes ☐ Never

Which type of group are you most comfortable with? ☐ Large group ☐ Small group (2-7) ☐ One other person

How often do you socialize with close friends, relatives, or neighbors in your home? ☐ Daily ☐ Weekly ☐ Monthly ☐ Not at all

How often do you socialize with close friends, relatives, or neighbors outside your home? ☐ Daily ☐ Weekly ☐ Monthly ☐ Not at all

Do you have a best friend with whom you confide? ☐ Yes ☐ No

Do you feel that any of the following behaviors get in your way when communicating and interacting with others? Please check all that apply.

☐ Making inappropriate comments
☐ Asking inappropriate questions
☐ Staying focused on a topic
☐ Maintaining personal space
☐ Getting agitated or angry
☐ None
☐ Other _____

Are you satisfied with the way you communicate with others? ☐ Yes ☐ No

Would you like to make any changes to the way you currently interact and communicate with others? ☐ Yes ☐ No

If YES, please describe the changes you would like to make: _____

Comments: _____

8. COMMUNITY LIVING AND PEER RELATIONSHIPS

Do you have transportation available to you that you can rely on? ☐ Yes ☐ No

How do you usually travel to the places you need to go to?

☐ Personal Vehicle ☐ Personal adapted vehicle ☐ Public transportation ☐ Other

Do you currently have working telephone service? ☐ Yes ☐ No If NO, why not? _____

Community Living and Peer Relationships – continued…

Do you currently have a working cell phone? ☐Yes ☐No If YES, do you keep it with you at all times? ☐Yes ☐No

Do you have a working fire alarm in your home? ☐Yes ☐No

How often do you test the batteries in the fire/smoke alarm? _____

Do you have a fire extinguisher in your home? ☐Yes ☐No

If YES, can you or someone in your home physically use it? ☐Yes ☐No

Do you have a plan in place for emergencies (For example, an evacuation plan in case of a fire or hurricane)? ☐Yes ☐No

Does your phone service have 911 access? ☐Yes ☐No

Are emergency telephone numbers posted in a prominent place in your home or programmed into a phone? ☐Yes ☐No

Is the toll-free number for the SC Poison Control Center posted? (1-800-222-1222) ☐Yes ☐No

Do you have a way to communicate with someone in an emergency? ☐Yes ☐No

If NO, would you like information on personal emergency response devices? ☐Yes ☐No

What financial resources are you currently receiving?

☐SSI ☐Earned income ☐Ongoing DDSN Family Support Stipends ☐VA Pension
☐SSDI ☐Food Stamps ☐Worker's Compensation ☐Other private disability insurance
☐SSA ☐Housing supplements

Are these resources adequate to meet your basic needs? ☐Yes ☐No ☐Sometimes

Do you have difficulty managing your financial resources? ☐Yes ☐No

Does someone else regularly manage your finances for you? ☐Yes ☐No If YES, who? _____

Are you involved with any activities in your community? ☐Yes ☐No

If YES, check all that apply: ☐Church ☐Support groups ☐Community groups ☐Volunteer work ☐Civic organizations

Which of the activities you checked above have you been involved in during the past month?

☐Church ☐Support groups ☐Community groups ☐Volunteer work ☐Civic organizations

Are you currently involved in a support group? ☐Yes ☐No

If YES, how often do you attend support group meetings? ☐Once a month ☐Less than once a month ☐More than once a month

If NO, would you like to become more involved? ☐Yes ☐No

What leisure/recreational activities (Example: Varsity/college ballgames, swimming, movies, internet, museums, concerts, reading, shopping, gardening, camping, board games etc.) have you participated in during the past month?

_____

_____

_____

Are you satisfied with your participation in leisure/recreation activities? ☐Yes ☐No If NO, what changes would you like to make?

_____

_____

_____

Have you heard of peer supports? ☐Yes ☐No

Could you benefit from an appropriate "peer support" service? ☐Yes ☐No

How many peers have you communicated with in the last month (by phone, visiting, writing, or using email)? _____

How many relatives have you communicated with in the last month (by phone, visiting, writing, or using email)? _____

Are there any other issues you would like to discuss that have not been addressed? _____

_____

_____

_____

_____

_____

Comments: _____

9. AFTER COMPLETING ASSESSMENT, WHAT DO YOU THINK YOU NEED HELP WITH?

A. **Please list <u>in order of importance</u> to you**:

B. **Please write in training needs identified according to HASCI core competency area:**

1. Health and Safety:

2. Advocacy and Self-Determination:

3. Independent Functioning:

4. Productive Lifestyles:

5. Community Linkages and Natural Supports:

6. Vocational Opportunities:

Life Skills Specialist Signature (Lead Clinical Staff) *Date*

Please PRINT Below

Life Skills Specialist (Lead Clinical Staff) ( ) Phone

DSN Board